

TEXAS HIGHER EDUCATION COORDINATING BOARD
Family Practice Resident's Rural Rotation
Rural Rotation Grant Request

- | | |
|---|--|
| 1. Family Practice Residency Program
(Include name, address, phone
number and contact person)

_____ | 2. Date of request _____
3. Name of resident _____
4. Name of supervisor _____
5. Rotation site _____
6. Rotation dates _____ to _____ |
|---|--|

Resident must complete the entire one-month rotation

7. A Rural Rotation Grant is requested to cover the expenditures for a Rural Rotation as follows:

- | | |
|--|---|
| a. Resident stipend _____ | |
| b. Resident travel _____
(One round trip not
to exceed \$500) | |
| c. Resident meals _____
(Items c & d not to
exceed \$500 total) | To be paid by program to supervisor/
hospital. Name of supervisor/hospital:
_____ |
| d. Resident lodging _____ | To be paid by program to supervisor/
hospital. Name of supervisor/hospital:
_____ |
| e. Program expense _____ | _____ |

8. **Total amount requested** _____

**The Resident's and Residency Program Director's
Evaluation of the Rotation Must be Attached to this Form.**
Programs are to retain all receipts and documents for this rotation for four years.

9. I certify that the above expenditures were incurred as a result of a Rural Rotation that meets Coordinating Board guidelines, and that all evaluations have been completed and returned to the appropriate persons.

Name of Program Director

Signature of Program Director

To be completed by the Coordinating Board.

This request is correct and proper and is approved for payment.

Signature, Certifying Official

Assistant Commissioner
Title

Date